# STATE OF MARYLAND - DEPARTMENT OF BUDGET AND MANAGEMENT

# COBRA/LAWP/CONTRACTUAL/PART-TIME JANUARY-JUNE 2005 WORKSHEET

## PERSONAL DATA

**EMPLOYEE'S/RETIREE'S INFORMATION**

**Name:**
**Address:**
**City** **State** **Zip Code**

**Home Phone: (  ) __ __ __- __ __ __ __**
**Work Phone: (  ) __ __ __ - __ __ __ __**

**Social Security Number: __ __ __ /__ __ / __ __ __ __**

**Date of Birth: ____/____/_____**

**Sex:** ○ **Male** ○ **Female**

**MARITAL STATUS:**
S ○ Single W○ Widowed
M○ Married D ○ Divorced
L ○ Separated

**APPLICANT'S INFORMATION**
**( if different from employee's information)**

**Name:**
**Address:**
**City** **State** **Zip Code**

**Home Phone: (  ) __ __ __- __ __ __ __**
**Work Phone: (  ) __ __ __ - __ __ __ __**

**Social Security Number: __ __ __ /__ __ / __ __ __ __**

**Date of Birth: ____/____/_____**

**Sex:** ○ **Male** ○ **Female**

**MARITAL STATUS:**
S ○ Single W○ Widowed
M○ Married D ○ Divorced
L ○ Separated

## STATUS & ENROLLMENT/CHANGE ACTION REQUESTED

**STATUS**

○ COBRA Date of Qualifying Event:_____
Are you on Medicare? ○ Yes ○ No
○ Former Employee or Retiree OR Dependent of Employee or Retiree
○ Former Contractual Employee or Dependent of Contractual Employee
○ Former Satellite Employee or Dependent of Satellite Employee
○ Former LAWP or Dependent of LAWP (Leave of Absence Without Pay)
○ **LAWP** (Long Term Leave of Absence Without Pay)
Is this an on the job injury? ○ Yes ○ No
Effective Date of LAWP:_____
End Date of LAWP:_____
○ Contractual -
Contract Period: From _____ To _____
○ Part-time Employee (Less than 50%)
○ Former Active Employee Now Working Part-Time (Less than 50%)

**ENROLLMENT/CHANGE ACTION REQUESTED**

○ Open Enrollment
○ New Enrollment
○ Cancel All Coverage in All Plans
○ Change in Family Status
  ○ Add spouse/dependent because of:
    ○ Marriage. Date:_____
    ○ Birth/Adoption/Appointed permanent legal guardian. Date:_____
    ○ Resumed student status. Date:_____
    ○ Other: _____
  ○ Remove spouse/dependent because of:
    ○ Divorce/Limited Divorce. Date: _____
    ○ Death of: _____ Date:_____
    ○ Dependent no longer eligible - Effective:_____
    ○ Other: _____

## *Medical Benefits*

***OPTIONS***
○ New Enrollment or Change in Plan
○ Change of coverage level
○ No, I do not want to start this benefit
○ Cancel all medical benefits coverage

***COVERAGE LEVEL***
○ Individual Only
○ Individual plus one child; specify_____
○ Individual plus spouse
○ Individual plus two or more
○ End Stage Renal (ESRD)

***MEDICAL PLANS***

*PPO Plans:*
1 ○ BC/BS PPO
2 ○ MLH Eagle PPO

*POS Plans:*
1 ○ Aetna POS
2 ○ BC/BS MD POS
3 ○MD IPA Preferred POS

*HMO Plans*
1 ○ BlueChoice HMO
2 ○ Kaiser HMO
3 ○ Optimum Choice HMO

*Vision benefits are included in all Medical Plans.Contact Medical Plan for Vision benefits.*

***If you or a dependent have Medicare, write in name, Medicare number, effective date of Medicare coverage level.***

*Name* _____ *Medicare Number* _____ *Date of Coverage* ___/____/_____
*Name* _____ *Medicare Number* _____ *Date of Coverage* ___/____/_____

# *ENROLLMENT FOR JANUARY-JUNE 2005*

# E N R O L L M E N T  W O R K S H E E T

## *Prescription Coverage*

***OPTIONS***
○ New enrollment or change in plan
○ Addition or removal of dependent
○ No, I do not want to start this benefit
○ Cancel current coverage

***COVERAGE LEVEL***
○ Individual Only
○ Individual plus one child; specify_____
○ Individual plus spouse
○ Individual plus two or more

***Prescription Drug is not included in any medical plan. You must be enrolled in the Prescription Drug Plan if you want this benefit.***

## *Dental Coverage*

***OPTIONS***

○ New enrollment or change in plan
○ Addition or removal of dependent
○ No, I do not want to start this benefit
○ Cancel current coverage

***COVERAGE LEVEL***

○ Individual Only
○ Individual plus one child; specify_____
○ Individual plus spouse
○ Individual plus two or more

***DENTAL PLANS***
***Check only one dental plan:***
1 ○ Dental Benefits Providers Dental HMO
*Or*
2 ○ United Concordia Dental HMO
*Or*
3 ○ United Concordia Dental PPO

***Dental is not included in any Medical plan. You must be enrolled in a Dental Plan if you want this benefit.***

## *Personal Accident and Dismemberment Benefits Available to LAWP/Contractual/Part-Time Only*

***(NOT AVAILABLE TO COBRA ENROLLEES)***

***For Contractual/Part-Time Employees Only:***

***OPTIONS***
○ New Enrollment or addition/removal of dependent
○ Change of benefit amount - make a $ selection
○ No, I don t want to start this benefit
○ Cancel current coverage

***COVERAGE LEVEL***
○ Employee only coverage
○ Family coverage

***BENEFIT AMOUNT***
○ $100,000
○ $200,000
○ $300,000

***For Employees On LAWP (Effective 1/1/2005)***

○ I want to continue my coverage
Make a $ selection

○ Cancel my coverage

## *Spending Accounts - Health Care and/or Dependent Care*

***For Employees Who Had Spending Accounts on Active Status In January-June 2005**

**THIS IS NOT A PRE-TAX BENEFIT AND FUNDS MUST BE WITHDRAWN BY October 15, 2005**

**BK Health Care Spending Account**
○ I want to continue my Health Care Spending Account in January-June 2005. I understand that I will be billed for the same total $ amount as in active plus a 2% fee for COBRA enrollees.
○ Cancel my Health Care Spending Account.

**BN Day Care Spending Account**
○ I want to continue my Day Care Spending Account in January-June 2005. I understand that I will be billed for the same $ amount as in active status, plus a 2% fee for COBRA enrollees.
○ Cancel my Day Care Spending Account.

*ENROLLMENT FOR JANUARY-JUNE 2005*

# E N R O L L M E N T  W O R K S H E E T

## *Life Insurance (AX) - Benefits Available to LAWP/Contractual/Part-Time Only*

**APPLICANT LIFE INSURANCE (NOT AVAILABLE TO COBRA ENROLLEES)**

***For Contractual/Part-Time Employees Only:***

○ Yes, I want to continue my January-June 2005 level of coverage, Make a $ selection.
○ Yes, I want to continue my Life Insurance, but at a different coverage level. Make a $ selection.
○ Yes, I want to enroll as a new enrollee in Life Insurance. Make a $ selection.
○ No, I do not want to start this benefit
○ Cancel all Life Insurance (applicant and dependent)

○ $ 10,000
○ $ 20,000
○ $ 30,000
○ $ 40,000
○ $ 50,000

**NOTE: If you choose an amount $60,000 or over, you must attach a Statement of Health to this form.**

| | | | | |
|---|---|---|---|---|
| ○ $ 60,000 | ○ $110,000 | ○ $160,000 | ○ $210,000 | ○ $260,000 |
| ○ $ 70,000 | ○ $120,000 | ○ $170,000 | ○ $220,000 | ○ $270,000 |
| ○ $ 80,000 | ○ $130,000 | ○ $180,000 | ○ $230,000 | ○ $280,000 |
| ○ $ 90,000 | ○ $140,000 | ○ $190,000 | ○ $240,000 | ○ $290,000 |
| ○ $100,000 | ○ $150,000 | ○ $200,000 | ○ $250,000 | ○ $300,000 |

***For Employees on LAWP:**

○ I want to continue my life Insurance at the same $ value as in active status. Make a $ selection.

○ No, I do not want to start this benefit
○ Cancel all Life Insurance (applicant and dependents)

**DEPENDENT LIFE INSURANCE (NOT AVAILABLE TO COBRA ENROLLEES)**

***For Contractual/Part-Time Employees Only:***

**Life Insurance on Spouse**

○ Yes, I want to continue my spouse's life insurance at the January-June 2005 level.
○ Yes, I want to continue my spouse's life insurance, but at a different amount. Mark a $ selection.
○ Yes, I choose Dependent Life Insurance for my spouse. Mark a $ selection.
○ No, I do not want to start this benefit.
○ Cancel Life Insurance on spouse.

*Fill in the amount* ***Amount of Benefit***

$ □ □ □ , ● ● ●

***(Available up to 50% of employee's coverage in increments of $5,000 only.)***

**Life Insurance on Child(ren)**

○ Yes, I want to continue my child(ren)'s life insurance at the January-June 2005 level. Mark a $ selection.
○ Yes, I want to continue my child(ren)'s life insurance, but at a different amount. Mark a $ selection.
○ Yes, I want new life insurance on my child(ren). Mark a $ selection.
○ No, I do not want to start this benefit.
○ Cancel Life Insurance on child(ren)

*Fill in the amount* ***Amount of Benefit***

$ □ □ □ , ● ● ●

***(Available up to 50% of employee's coverage in increments of $5,000 only.)***

***If you choose an amount over $25,000 for your spouse and/or child(ren) you must complete a Statement of Health Form for your spouse or children.***

****For Employees on LAWP (Effective 1/1/2005 - 6/30/2005)***

**Continue Life Insurance on Spouse**

○ I want to continue my Dependent Life Insurance on my spouse at the same $ value as in active status. (Mark a $ selection above.)
○ Cancel Dependent Life Insurance on my spouse.

**Continue Life Insurance for Child(ren)**

○ I want to continue my Dependent Life Insurance on my child(ren) at the same $ value as in active status. (Mark a $ selection above.)
○ Cancel Dependent Life Insurance on my child(ren).

*ENROLLMENT FOR JANUARY-JUNE 2005*

# E N R O L L M E N T  W O R K S H E E T

## *COBRA - Consolidated Omnibus Budget Reconciliation Act*

***You and your eligible dependents may continue health coverage if one of the following qualifying events occurs:***

| **Mark one of the following:** **QUALIFYING EVENT** | **PERIOD OF TIME ELIGIBLE FOR CONTINUATION*** |
|---|---|
| ○ 1. Terminated employee (other than for gross misconduct) | 18 months or until eligible for group coverage through another source including Medicare |
| ○ 2. Resigned | 18 months or until eligible for group coverage through another source including Medicare |
| ○ 3. Laid off employee | 18 months or until eligible for group coverage through another source including Medicare |
| ○ 4. Employee whose hours have been involuntarily reduced | 18 months or until eligible for group coverage through another source including Medicare |
| ○ 5.Divorce or legally separated spouse of a current State employee/retiree | Indefinitely or until eligible for group coverage through another source including Medicare |
| **QUALIFYING EVENT** | **PERIOD OF TIME ELIGIBLE FOR CONTINUATION*** |
| ○ 6. Spouse of a State employee who has elected Medicare as primary coverage and the spouse is not eligible for Medicare | 36 months or until eligible for group coverage through another source including Medicare |
| ○ 7. Previously dependent child of an employee who is no longer eligible by reason of age, marriage, loss of student status or death of employee | 36 months or until eligible for group coverage through another source including Medicare |
| ○ 8. Widowed spouse of a State employee/retiree | 36 months or until eligible for group coverage through another source including Medicare |

***The period of time is the number of months listed, or until eligible for coverage elsewhere, whichever is less.***

## *LAWP - Long Term Leave Without Pay*

An employee on an approved Long Term Leave of Absence without pay (LAWP) exceeding two pay periods (one pay period for employees who are paid monthly) may continue any or all of the health benefit plans in which the employee has enrolled while on active status.

If the long term LAWP is the result of a job-related accident or injury, the State will pay the State portion and the individual will pay the employee portion. If the long term LAWP is due to any other reason, the individual must pay 100 percent of the premium. In either case the employee will be billed by the Department of Budget & Management for the amount due.

**AGENCY BENEFITS COORDINATOR - PLEASE PRINT THE FOLLOWING:**

A. _____ is on Approved Leave
Employee s Name

of Absence Without Pay effective _____
Date

○ as a result of a job-related accident or injury (INCLUDE A COPY OF THE FIRST REPORT OF INJURY FORM AND HAVE FISCAL OFFICER COMPLETE BELOW)
○ for any other reason; describe: _____

B. Anticipated date of return to work: _____
Date

C. Is this an initial LAWP? ○ Yes ○ No **OR** Is this an extension of a previous Long Term LAWP? ○ Yes ○ No

D. _____ _____
Agency Benefits Coordinator s Name (PRINT) Phone Number

_____
Agency

_____ _____ / _____ / _____
Agency Address Date

_____
Signature of Agency Benefits Coordinator or Appointing Authority

**FISCAL OFFICER - PLEASE PRINT THE FOLLOWING (only if State subsidized LAWP)**

Appropriation Code: ☐☐☐ ☐☐☐☐☐ ☐☐☐ ☐☐☐☐
Agency PCA TC R Stars Sub Object

_____ _____
Fiscal Officer Name & Phone Number Fiscal Officer Signature

# *ENROLLMENT FOR JANUARY-JUNE 2005*

# E N R O L L M E N T  W O R K S H E E T

## *Dependent Information*

The following is reserved for dependent information. PLEASE PRINT. DO NOT TYPE. THIS MUST BE FILLED OUT TO INSURE YOUR DEPENDENTS ARE TRANSFERRED OVER TO THE PLANS FOR PROPER COVERAGE. You may use this section for additions(A), deletions (D), or changes (C) to your existing health benefits file for open enrollment or a qualifying event. Please print only - Dependents include spouse and children.

| *A/ C/D* | *DC* | *LAST NAME* | *FIRST NAME* | *MI* | *SEX* | *BIRTH DATE* | *RELATION-SHIP* | *SOCIAL SECURITY NO.* | *COVER THIS DEPENDENT FOR: HEALTH* | *DRUG* | *DENTAL* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |
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***THIS MUST BE FILLED IN FOR PROPER COVERAGE. Dependent children over age 23 must be disabled.***

## *Applicant and Agency Signatures*

***If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a member service representative before signing this application.***

Please enroll me for the benefits indicated on this form. I understand the benefits and limitations provided by the various plans. To the extent deemed necessary by the Plan Administrator for the proper administration of my coverages, I authorize the release of all medical records and related information pertaining to me or to my dependents. The personal information provided on this enrollment form is warranted to be complete, accurate, and in accordance with Department of Budget & Management regulations. I understand that I cannot cancel or change my enrollment except during an Open Enrollment period or as the result of a qualifying change in family status permitted by Section 125 of the Internal Revenue Code.

I understand that the Benefits Program offered by the State is subject to modifications and changes and that the benefits I have chosen in this enrollment form are only in effect for January-June 2005. The State of Maryland reserves the right to modify any benefits provided and gives no assurances, expressed or implied, that any coverage obtained hereunder will continue beyond January-June 2005. I certify that neither I nor my family members are covered under another State of Maryland employee's or retiree's membership.

I understand that enrollment in benefits to which I am not entitled is considered fraud. In all cases I am responsible for the accuracy of my benefits, coverage levels and deductions. I further understand that if I willfully misrepresent the eligibility of myself or my dependents on my health benefits application, or fail to take the necessary action to remove ineligible dependents, or in any way obtain benefits to which I am not entitled, my benefits will be canceled, I will be required to repay any claims and insurance premiums, and I may face charges for dismissal from State service.

**Is there any other health insurance in which you, your spouse or any of your dependents are enrolled?** ○ Yes ○ No

**Specify who is covered, name of Insurance Company and Policy Number:** _____

X _____
Your Signature

_____ /_____ /_____ ☐☐☐-☐☐☐-☐☐☐☐
Date Your Work/Day Time Phone Number

X _____
AGENCY SIGNATURE - Agency Must Sign Here

_____ /_____ /_____ ☐☐☐-☐☐☐-☐☐☐☐
Date Work Phone Number (Ext.)

Agency Code: ☐☐☐☐☐☐ _____
Department

**COMPLETED AND SIGNED ENROLLMENT FORMS SHOULD BE MAILED OR HAND-DELIVERED TO:**

**Employee Benefits Division**
**301 W. Preston Street**
**Room 510**
**Baltimore, Maryland 21201**